-APPLICATION FOR TELECOMMUNICATIONS EQUIPMENT-

MTAP OFFICE USE:
DATE RECEIVED:_____/_____/_____ CLIENT ID #:_____
APPLICANT IS: APPROVED____ DENIED____ MISSING INFORMATION____

GENERAL INFORMATION

SSN_____Birthdate:_____/_____/_____

Name:_____
Last First MI

Street Address:_____
Street City Zip

Mailing Address (if different):_____
RR, HC, PO Box City Zip

Phone #:_____Email:_____

I am a resident of Montana: ___Yes ___No

Is a home visit necessary (e.g. Is the applicant house-bound)? ____Yes ___No
Reason for request of home visit:_____

Please provide an additional contact person:

Name:_____Phone #:_____

Address:_____City:_____Zip:_____

Relationship to Applicant:_____

How did you hear about MTAP?
___Newspaper Story ___Newspaper Ad ___Phone Company ___TV News ___TV Ad ___Internet
___Audiologist ___Phone Book ___Friend/Family ___Presentation ___ Mailing Piece ___ Other

Would you like to be added to the MTAP mailing list? ___Yes ___No

FEDERAL ELIGIBILITY
Are you a: ___ Veteran ___ Native American ___ Current Federal Employee
___ Former Federal Employee

DISABILITY AND EQUIPMENT INFORMATION
The applicant is (check one):

___Deaf ___Hard of Hearing ___Speech Disabled ___Deaf/Blind
___Visually Disabled plus Hard of Hearing ___Mobility Disabled

If Mobility Disabled, please describe:_____

The applicant requests (check all that may apply):
___TTY and Signal Device ___Large Print TTY and Signal Device

___Amplified Telephone ____Loud Ringer ___Cochlear Implant Compatible Phone

___"CapTel" Captioned Telephone

___Weak Speech Amplified Telephone ___Artificial Larynx

___"Hands Free" Speakerphone (mobility disabled only)

___I need (specify brand/model):_____

___I need MTAP to help me determine what equipment will work the best for me.

INCOME INFORMATION
Total number of family members living in household:_____

Total annual family gross income from Social Security and/or regular paycheck if applicable:
$_____per year

Note: No retirement funds, pension funds or investment dividend payments are reportable. Applicant's family income must be lower than 250% of the current year's Federal Poverty Guidelines (see "Instructions and Information" for amounts) to qualify. Participation in our program is based on household income along with the number of persons which that income supports.

VERIFIER INFORMATION
The professional listed below can verify my disability:
Note: You may not list yourself, a family member, or relative. This can be any medical professional who can verify your hearing, speech or mobility disability ***You do not need a signature from the verifier.***

Name:_____Telephone #:_____

Address:_____City:_____Zipcode:_____

Verifier's Occupation (check one):
___Licensed Physician ___Voc. Rehab. Counselor ___Audiologist
___Hearing Aid Specialist/Dispenser ___Speech Pathologist ___Other:_____

APPLICATION CERTIFICATION
I certify under penalty of the offense of false swearing (Section 45-7-202, MCA), that I meet the definition of Deaf, Deaf/Blind, Hard of Hearing, Speech Disabled, or Motion/Mobility Disabled given on the application instruction sheet and that all statements made by me are true and correct to the best of my knowledge. I also agree to inform the Montana Telecommunications Access Program (MTAP) of any changes to this information as long as I am receiving services.

Applicant's Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____
(Required if applicant is under the age of 18)